DRAFT (09-18-03) (HEALTH) **__. B. ____**

FINAL DRAFT

HEALTH INSURANCE LAW AMENDMENTS

2004 GENERAL SESSION

STATE OF UTAH

Sponsor:

AN ACT RELATING TO INSURANCE; RELATING TO

("SUMMARY")

This act affects sections of Utah Code Annotated 1953 as follows:

AMENDS:

31A-2-201, as last amended by Chapter 277, Laws of Utah 2001
31A-21-201, as last amended by Chapter 252, Laws of Utah 2003
31A-22-610.5, as last amended by Chapters 116 and 207, Laws of Utah 2001
31A-22-629, as last amended by Chapter 42, Laws of Utah 2003
31A-22-701, as last amended by Chapter 116, Laws of Utah 2001
31A-22-716, as last amended by Chapter 116, Laws of Utah 2001
31A-22-717, as last amended by Chapter 116, Laws of Utah 2001
31A-30-101, as last amended by Chapter 308, Laws of Utah 2002
31A-30-106, as last amended by Chapter 252, Laws of Utah 2003

Be it enacted by the Legislature of the state of Utah:

Section X. Section **31A-2-201** is amended to read:

31A-2-201. General duties and powers.

(1) The commissioner shall administer and enforce this title.
(2) The commissioner has all powers specifically granted, and all further powers that are reasonable and necessary to enable him to perform the duties imposed by this title.
(3) (a) The commissioner may make rules to implement the provisions of this title according to the procedures and requirements of Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(b) In addition to the notice requirements of Section 63-46a-4, the commissioner shall provide notice under Section 31A-2-303 of hearings concerning insurance department rules.

(4) (a) The commissioner shall issue prohibitory, mandatory, and other orders as necessary to secure compliance with this title. An order by the commissioner is not effective unless the order:

(i) is in writing; and

(ii) is signed by the commissioner or under the commissioner's authority.

(b) On request of any person who would be affected by an order under Subsection (4)(a), the commissioner may issue a declaratory order to clarify the person's rights or duties.

(5) (a) The commissioner may hold informal adjudicative proceedings and public meetings, for the purpose of investigation, ascertainment of public sentiment, or informing the public.

(b) No effective rule or order may result from informal hearings and meetings unless the requirement of a hearing under Section 31A-2-301 is satisfied.

(6) The commissioner shall inquire into violations of this title and may conduct any examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, that he considers proper to determine:

(a) whether or not any person has violated any provision of this title; or

(b) to secure information useful in the lawful administration of any provision of this title.

(7) (a) Each year, the commissioner shall:

(i) conduct an evaluation of the state's health insurance market;

(ii) report the findings of the evaluation to the Health and Human Services Interim Committee before [~~July 31~~]October 1; and

(iii) publish the findings of the evaluation of the department website.

(b) The evaluation shall:

(i) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of Utahns by assessing such things as the availability and marketing of individual and group products, rate charges, coverage and demographic changes, benefit trends, market share changes, and accessibility;

(ii) assess complaint ratios and trends within the health insurance market, which assessment shall integrate complaint data from the Office of Consumer Health Assistance within the department;

(iii) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and

(iv) include claims loss ratio data for each insurance company doing business in the state.

(c) When preparing the evaluation required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

Section X. Section **31A-21-201** is amended to read:

31A-21-201. Filing [~~and approval~~] of forms.

(1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may not be used, sold, or offered for sale unless the form has been filed with the commissioner.

(b) A form is considered filed with the commissioner when the commissioner receives:

(i) the form;

(ii) the applicable filing fee as prescribed under Section 31A-3-103; and

(iii) the applicable transmittal forms as required by the commissioner.

(2) In filing a form for use in this state the insurer is responsible for assuring that the form is in compliance with this title and rules adopted by the commissioner.

(3) (a) The commissioner may prohibit the use of a form at any time upon a finding that:

(i) the form is:

(A) inequitable;

(B) unfairly discriminatory;

(C) misleading;

(D) deceptive;

(E) obscure;

(F) unfair;

(G) encourages misrepresentation; or

(H) not in the public interest;

(ii) the form provides benefits or contains other provisions that endanger the solidity of the insurer;

(iii) in the case of the basic policy and the application for a basic policy, the basic policy or application for the basic policy fails to conspicuously, as defined by rule, provide:

(A) the exact name of the insurer;

(B) the state of domicile of the insurer filing the basic policy or application for the basic policy; and

(C) for life insurance and annuity policies only, the address of the administrative office of the insurer filing the basic policy or application for the basic policy;

(iv) the form violates a statute or a rule adopted by the commissioner; or

(v) the form is otherwise contrary to law.

(b) Subsection (3)(a)(iii) does not apply to riders and endorsements to a basic policy.

(c) (i) Whenever the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the order, the use of the form be discontinued.

(ii) Once a form has been prohibited, the form may not be used unless appropriate changes are filed with and reviewed by the commissioner.

(iii) Whenever the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to existing policyholders.

(d) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:

(i) be in writing;
(ii) constitute an order; and
(iii) state the reasons for the prohibition.
(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that certain forms be subject to the commissioner's approval prior to their use.
(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for the forms if the procedures are different than the procedures stated in this section.
(c) The types of forms that may be addressed under Subsection (4)(a) include:
(i) a form for a particular class of insurance;
(ii) a form for a specific line of insurance;
(iii) a specific type of form; or
(iv) a form for a specific market segment.
(5) (a) An insurer shall maintain a complete and accurate record of the following for the time period described in Subsection (5)(b):
(i) any form:
(A) filed under this section for use; and
(B) that is in use; and
(ii) any document filed under this section with a form described in Subsection (5)(a)(i).
(b) The insurer shall maintain a record required under Subsection (5)(a) for the balance of the current year, plus three years from:
(i) the last day on which the form is used; or
(ii) the last day any policy that is issued using the form is in effect.

Section X. Section **31A-22-610.5** is amended to read:

31A-22-610.5. Dependent coverage.

(1) As used in this section, "child" has the same meaning as defined in Section 78-45-2.
(2) (a) Any individual or group health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday and shall, upon application, provide coverage for all unmarried dependents up to age 26.
(b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be included in the premium on the same basis as other dependent coverage.
(c) This section does not prohibit the employer from requiring the employee to pay all or part of the cost of coverage for unmarried dependents.
(3) An individual or group health insurance policy or health maintenance organization contract shall reinstate dependent coverage, and for purposes of all exclusions and limitations, shall treat the dependent as if the coverage had been in force since it was terminated; if:

(a) the dependent has not reached the age of 26 by July 1, 1995;

(b) the dependent had coverage prior to July 1, 1994;

(c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age of the dependent; and

(d) the policy has not been terminated since the dependent's coverage was terminated.

(4) (a) When a parent is required by a court or administrative order to provide health insurance coverage for a child, an accident and health insurer may not deny enrollment of a child under the accident and health insurance plan of the child's parent on the grounds the child:

(i) was born out of wedlock and is entitled to coverage under Subsection (6);

(ii) was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;

(iii) is not claimed as a dependent on the parent's federal tax return; or

(iv) does not reside with the parent or in the insurer's service area.

(b) An accident and health insurer providing enrollment under Subsection (4)(a)(iv) is subject to the requirements of Subsection (5).

(5) A health maintenance organization or a preferred provider organization may use alternative delivery systems or indemnity insurers to provide coverage under Subsection (4)(a)(iv) outside its service area. Section 31A-8-408 does not apply to this Subsection (5).

(6) When a child has accident and health coverage through an insurer of a noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer shall:

(a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection (6)(a), whether the information is provided pursuant to a verbal or written request;

(b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) make payments on claims submitted in accordance with Subsection (6)(b) directly to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid agency.

(7) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. 651 through 669, the child support enforcement program; and

(c) (i) when the child is covered by an individual policy, not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) the court or administrative order is no longer in effect; or

(B) the child is or will be enrolled in comparable accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment; or

(ii) when the child is covered by a group policy, not disenroll or eliminate coverage of the child unless the employer is provided with satisfactory written evidence, which evidence is also provided to the insurer, that Subsection (10)(c)(i), (ii) or (iii) has happened.

(8) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

(9) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.

(10) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:

(a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. 651 through 669, the child support enforcement program;

(c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:

(i) the court order is no longer in effect;

(ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(iii) the employer has eliminated family health coverage for all of its employees; and

(d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.

(11) An order issued under Section 62A-11-326.1 may be considered a "qualified medical support order" for the purpose of enrolling a dependent child in a group accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

(12) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:

(a) the parent continues to be eligible for coverage;

(b) the child shall be identified to the insurer with adequate information to comply with this section; and

(c) the premium shall be paid when due.

(13) The provisions of this section apply to employee welfare benefit plans as defined in Section 26-19-2.

(14) The commissioner shall adopt rules interpreting, describing and clarifying this section with regard to Out-of-Area Court Ordered Dependent Coverage.

Section X. Section **31A-22-629** is amended to read:

31A-22-629. Adverse benefit determination review process.

(1) As used in this section:

(a) (i) "Adverse benefit determination" means the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or in part, for a benefit.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

(B) with respect to individual or group health plans, and income replacement or disability income policies, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; and

(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(I) experimental;

(II) investigational; or

(III) not medically necessary or appropriate.

(b) "Independent review" means a process that:

(i) is a voluntary option for the resolution of an adverse benefit determination;

(ii) is conducted at the discretion of the claimant;

(iii) is conducted by an independent review organization designated by the insurer;

(iv) renders an independent and impartial decision on an adverse benefit determination submitted by an insured; and

(v) may not require the insured to pay a fee for requesting the independent review.

(c) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.

(d) "Insurer" is as defined in Section 31A-1-301 and includes:

(i) a health maintenance organization; and

(ii) a third-party administrator that offers, sells, manages, or administers a health insurance policy or health maintenance organization contract that is subject to this title.

(e) "Internal review" means the process an insurer uses to review an insured's adverse benefit determination before the adverse benefit determination is submitted for independent review.

(2) This section applies generally to health insurance policies, health maintenance organization contracts, and income replacement or disability income policies.

(3) (a) An insured may submit an adverse benefit determination to the insurer.

(b) The insurer shall conduct an internal review of the insured's adverse benefit determination.

(c) The insured who disagrees with the results of an internal review may submit the adverse benefit determination for an independent review if the adverse benefit determination involves payment of a claim or denial of coverage.

(4) Before October 1, 2000, the commissioner shall adopt rules that establish minimum standards for:

(a) internal reviews;
(b) independent reviews to ensure independence and impartiality;
(c) the types of adverse benefit determinations that may be submitted to an independent review; and
(d) the timing of the review process, including an expedited review when medically necessary.
(5) Nothing in this section may be construed as:
(a) expanding, extending, or modifying the terms of a policy or contract with respect to benefits or coverage;
(b) permitting an insurer to charge an insured for the internal review of an adverse benefit determination;
(c) restricting the use of arbitration in connection with or subsequent to an independent review; or
(d) altering the legal rights of any party to seek court or other redress in connection with:
(i) an adverse decision resulting from an independent review, except that if the insurer is the party seeking legal redress, the insurer shall pay for the reasonable attorneys fees of the insured related to the action and court costs; or
(ii) an adverse benefit determination or other claim that is not eligible for submission to independent review.

Section X. Section **31A-22-701** is amended to read:

31A-22-701. Groups eligible for group or blanket insurance.

(1) A group or blanket accident and health insurance policy may be issued to:
(a) any group to which a group life insurance policy may be issued under Sections 31A-22-502 through 31A-22-507; or
[~~(b) a policy issued pursuant to a conversion privilege under Part VII; or~~
~~(c)~~](b) a group specifically authorized by the commissioner under section 31A-22-509, upon a finding that:
(i) authorization is not contrary to the public interest;
(ii) the proposed group is actuarially sound;
(iii) formation of the proposed group may result in economies of scale in administrative, marketing, and brokerage costs; and
(iv) the health insurance policy, certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to policies that are otherwise available to similar groups.
(2) Blanket policies may also be issued to:
(a) any common carrier or any operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to their travel status;
(b) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;

(c) an institution of learning, including a school district, school jurisdictional units, or the head, principal, or governing board of any of those units, as policyholder, covering students, teachers, or employees;

(d) any religious, charitable, recreational, educational, or civic organization, or branch of those organizations, as policyholder, covering any group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;

(e) a sports team, camp, or sponsor of the team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;

(f) any volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering any group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;

(g) a newspaper or other publisher, as policyholder, covering its carriers;

(h) an association, including a labor union, which has a constitution and bylaws and which has been organized in good faith for purposes other than that of obtaining insurance, as policyholder, covering any group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder;

(i) a health insurance purchasing association organized and controlled solely by participating employers as defined in Section 31A-34-103; and

(j) any other class of risks which, in the judgment of the commissioner, may be properly eligible for blanket accident and health insurance.

(3) The judgment of the commissioner may be exercised on the basis of:

(a) individual risks;

(b) class of risks; or

(c) both Subsections (3)(a) and (b).

Section X. Section **31A-22-716** is amended to read:

31A-22-716. Required provision for notice of termination.

(1) Every policy for group or blanket accident and health coverage issued or renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30 days prior written notice of termination to each employee or group member and to notify each employee or group member of his rights to continue coverage upon termination.

(2) An insurer's monthly notice to the policyholder of premium payments due shall include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers shall provide a sample notice to the policyholder at least once a year.

(3) For the purpose of compliance with federal law and the Health Insurance Portability and Accountability Act, public law No. 104-191, 110 Stat. 1960, all group, blanket or student health benefit policies must provide a certificate of creditable coverage to each covered person upon their termination from the plan as soon as reasonably possible.

Section X. Section **31A-22-717** is amended to read:

31A-22-717. Provisions pertaining to service members and their families affected by Operation Desert Shield and Operation Desert Storm.

For any group or blanket accident and health coverage, an insurer:

(1) may not refuse to reinstate an insured or his family whose coverage lapsed due to the insured's [~~participation in Operation Desert Shield or Operation Desert Storm~~] mobilization into the United States armed forces provided application is made within 180 days of release from active duty;

(2) shall reinstate an insured in full upon payment of the first premium without the requirement of a waiting period or exclusion for preexisting conditions or any other underwriting requirements that were covered previously; and

(3) may not increase the insured's premium in excess of what it would have been increased in the normal course of time had the insured not [~~participated in Operation Desert Shield or Operation Desert Storm~~ been mobilized into the United States armed forces.

Section X. Section **31A-30-101** is amended to read:

31A-30-101. Title.

This chapter is known as the "Individual, Small Employer, and Group [~~Employer~~] Health Insurance Act."

Section X. Section **31A-30-106** is amended to read:

31A-30-106. Premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for health benefit plans under this chapter are subject to the provisions of this Subsection (1).

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) (i) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except as provided in Section 31A-22-625.

(ii) A covered carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the covered carrier's rate manual for the class of business, except as provided in Section 31A-22-625; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the covered carrier's rate manual for the class of business.

(d) (i) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.

(ii) Any adjustment described in Subsection (1)(d)(i) shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) A covered carrier may use industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15%.

(f) (i) Covered carriers shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical groups that:

(A) differ only by the amounts attributable to plan design; and

(B) do not reflect differences due to the nature of the groups assumed to select particular health benefit products.

(iii) A covered carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(g) For the purposes of this Subsection (1), a health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use such a network, provided that use of the restricted network provision results in substantial difference in claims costs.

(h) The covered carrier may not, without prior approval of the commissioner, use case characteristics other than:

(i) age;

(ii) gender;

(iii) industry;

(iv) geographic area;

(v) family composition; and

(vi) group size.

(i) (i) The commissioner may establish rules in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, to:

(A) implement this chapter; and

(B) assure that rating practices used by covered carriers are consistent with the purposes of this chapter.

(ii) The rules described in Subsection (1)(i)(i) may include rules that:

(A) assure that differences in rates charged for health benefit products by covered carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit products;

(B) prescribe the manner in which case characteristics may be used by covered carriers;

(C) implement the individual enrollment cap under Section 31A-30-110, including specifying:

(I) the contents for certification;

(II) auditing standards;

(III) underwriting criteria for uninsurable classification; and

(IV) limitations on high risk enrollees under Section 31A-30-111; and

(D) establish the individual enrollment cap under Subsection 31A-30-110(1).

(j) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 200% of that expected for a standard insurable individual with the same case characteristics.

(k) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the covered carrier is actively enrolling new covered insureds.

(3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without regard:

(i) to case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

(4) (a) Each covered carrier shall maintain at the covered carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that the covered carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

(b) (i) Each covered carrier shall file with the commissioner, on or before [~~March 15~~]April 1 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the covered carrier is in compliance with this chapter; and

(B) the rating methods of the covered carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the covered carrier at the covered carrier's principal place of business.

(c) A covered carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63, Chapter 2, Government Records Access and Management Act.

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